STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395682	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop person-centered comprehensive care plans to meet resident care needs for three of three residents identified as an elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) risk (Residents R2, R3, and R4).Findings include: Review of facility policy Comprehensive Care Planning dated 5/4/26, indicated the facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. These plans will be focused on resident choices and abilities with the intent of maintaining or improving resident functional abilities and quality of life. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/10/26, indicated diagnoses of anxiety, depression, and age-related cognitive decline. Review of the clinical record indicated Resident R2 had an Elopement Observation assessment completed 5/11/26, with a Risk for Elopement scored 10 - potential risk for elopement. Immediate interventions included wander guard (a wearable electronic monitoring device). Review of Resident R2's comprehensive care plan dated 4/14/26, indicated the resident is at risk for elopement related to exit seeking behaviors and statements. Review of goals and interventions revealed the facility failed to develop person-centered interventions related to Resident R2's elopement risk status. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and mild intellectual disabilities. Review of the clinical record indicated Resident R3 had an Elopement Observation assessment completed 5/12/26, with a Risk for Elopement scored 8 - potential risk for elopement. Immediate interventions included wander guard. Review of Resident R3's comprehensive care plan dated 5/12/26, indicated the resident is at risk for elopement related to wandering. Review of goals and interventions revealed the facility failed to develop person-entered interventions related to Resident R3's elopement risk status. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), depression, and unspecified lack of coordination. Review of the clinical record indicated Resident R4 had an Elopement Observation assessment completed 5/10/26, with a Risk for Elopement scored 10 - potential risk for elopement. Immediate interventions included wander guard and on 3rd floor. Review of Resident R4's comprehensive care plan dated 5/11/26, indicated the resident is at risk for elopement related to wandering. Review of goals and interventions revealed the facility failed to develop person-entered interventions related to Resident R4's elopement risk status. During an interview on 5/20/26, at 9:03 a.m. the Nursing Home Administrator confirmed that the facility failed to develop person-centered comprehensive care plans to meet resident care needs for three of three residents identified as an elopement risk (Residents R2, R3, and R4). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record review, and staff interviews, it was determined that the facility failed to ensure proper supervision for a resident (Resident R1) resulting in an elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) from the facility. This failure created an immediate jeopardy situation (IJ) for all residents identified as an elopement risk.Findings include: Review of facility policy Elopement Unauthorized Absence dated 5/4/26, indicated the facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures to locate the resident in a timely manner. All residents will be assessed for the risk of elopement using the Elopement Observation on admission, quarterly, and as needed. Residents identified at risk will have interventions promptly implemented to reduce the risk of elopement. The resident's physician will be notified of risk and recommend interventions. The resident's responsible party will be informed of potential risk and interventions being implemented to provide for the resident's safety. Residents identified at risk will have their picture and face sheet or the demographic form placed in a binder that is kept in an area accessible by staff. Upon determining that a resident cannot be located a headcount will be conducted. If resident is still missing Code [NAME] using the resident name, room number, and unit name will be announced. Announce three times. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and hyperlipidemia (high levels of fats in the blood). Review of Resident R1's NSG - Admission/readmission Observation 3 assessment dated [DATE], stated, His caretaker brought him and told him they were just going to visit a friend. He knows the truth now and is very upset. Further review of Resident R1's NSG - Admission/readmission Observation 3 assessment dated [DATE], indicated an Elopement Observation was completed, which consisted of the following questions and documented answers: Is resident ambulatory or independent in wheelchair locomotion?YesDoes the resident have any of the following risk factors?New admission who has made statements questioning the need to be here - yesIs there been known history of attempted or actual elopement or unsafe wandering - noNot accepting present residency situation/location - noResident wanders without a sense of purpose - noDoes the resident have a history of substance abuse History (SUD) that may result in leaving the building - noResident exhibits exit seeking behaviors - noResident verbalizes, wanting to go home, going on a trip, going to meet someone - yesResident wanders in and out of other resident rooms and/or rummages in other's belongings - noCurrent acute change in cognition/confusion - noNone of the above criteria are currently exhibited - noPotential elopement risk identified, requires further review immediate intervention(s) implemented to address the identified risk factor(s) fillable sectionYesNo identified risk(s) for elopementNoImmediate intervention(s)On the 3rd floor due to more controlled environment. Has a TV (television) in room due to watching TV at home. Express wanting to be home but no prior elopement risk in the community. Score 4 - Level: currently potential risk for elopement risk for elopement Review of Resident R1's baseline care plan dated 5/7/26, indicated the resident was at risk for wandering. Interventions include resident will be monitored to minimize risk of wandering and/or elopement. Review of a progress note dated 5/7/26, at 3:21 p.m. stated, Patient very agitated because he wants to leave the facility. Patient care giver is with him trying to calm him down. He is yelling at her. He called his son to try to calm him but it was unsuccessful. Review of a progress note dated 5/7/26, at 7:10 p.m. stated, Patient continues to be agitated about being here. Advised him he will leave in 5 days. Review of a progress note dated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/9/26, at 1:54 p.m. stated, Resident does wander hallways ad lib (as desired). Transfers independently. Review of a progress note dated 5/10/26, stated, Resident R1 experienced an elopement event on 05/10/2026. Resident R1 was admitted on [DATE] for a 5-day respite stay (a short-term stay in a care facility that provides temporary professional care for a loved one while giving the primary caregiver a break) under the services of hospice with no known prior history of elopement behaviors. At approximately 12:20 PM, staff identified that the resident could not be located after last being observed at the third-floor nursing station at approximately 12:00 PM. The RN (Registered Nurse) Supervisor was notified immediately, an Elopement Code was initiated, and staff conducted a search of the center and surrounding grounds. After the resident could not be located, the Administrator and local police department were notified at approximately 12:44 PM. The resident was later found safely seated on the porch of a residence located at [0.5 miles away from the facility] and was retrieved without incident by the Director of Nursing Services (DON) and Maintenance Director. Upon return to the facility, at 1:31PM a full head-to-toe assessment identified no injuries or acute concerns. Emotional support was provided without signs or symptoms of distress observed or voiced. Family and physician were notified of the event. Immediate corrective actions included reassessment of the resident's elopement risk status, implementation of a WanderGuard (a wearable electronic monitoring device) device, and updating of the resident's care plan to reflect increased supervision and interventions related to elopement prevention. Review of a staff witness statement dated 5/10/26, completed by Nurse Aide (NA) Employee E7 stated, I noticed the resident missing after I went to pass his lunch tray and couldn't find him. I searched all the rooms and bathrooms and shower room. Then my coworkers started looking. Code [NAME] was called, we went outside to look for him. 2 coworkers and I drove around looking for him unfound. Went back to facility told supervisor where we looked and started picking up trays. Review of a staff witness statement dated 5/10/26, completed by NA Employee E8 stated, I went on my break around 11:37 a.m. When I left the nurses station Resident R1 was standing at the nurses station. I came back on the unit at 12:00 p.m. As soon as I came back I started help passing lunch trays. I was down the hall passing lunch trays when NA Employee E7 ask if Resident R1 was down the hall. I told her I had not seen him. She check C-Side (nursing unit) again. She came down A-Hall (nursing unit) saying he wasn't over there. So I started checking rooms and bathrooms. I could not find him. I checked back on to 3rd (floor) to see if he was found. He was not, so I went and drove around the area to see if I could help find him. Review of a staff witness statement dated 5/10/26, completed by Licensed Practical Nurse (LPN) Employee E3 stated, Resident was observed at desk before lunch trays. Staff and myself started passing trays. When we got to Resident R1's tray he was not in his room. Staff began searching unit for resident. When he was not on unit Code [NAME] called, supervisor noted myself and another staff member, then got in her car and began to search the blocks around the facility. Supervisor notified police and other responsible parties of incident. Returned to unit and awaited response from management. Review of a staff witness statement dated 5/10/26, completed by NA Employee E9 stated, I was charting in the hall waiting for lunch when an aide got off the elevator and she asked if we saw him. At that time she gave me his description while heading out the main door. I walked about 4 blocks down, looking down the alleys, streets, between houses and cars. I walked back a different way doing the same but wanted to get back to touch base. Review of a staff witness statement dated 5/10/26, completed by Maintenance Director Employee E10 stated, I along with the DON went to pick up Resident R1 at [a residence located 0.5 miles away from the facility] where his daughter told her he was. The resident was there sitting on the porch with the lady who lived there. We were able to get him into the car and back to the facility without incident. Review of a typed staff witness interview dated 5/10/26, indicated Receptionist Employee E1 stated, At approximately noon she observed a shorter gentleman in a ball cap and jacket near the front entrance area. She reported that the individual stated, Well I think I will go out for a while, and then exited through the facility front door. She stated she believed the individual was a visitor leaving the building and did not recognize the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	person as a resident at the time of the occurrence. She stated, I thought he was a visitor leaving, people do that all the time. She reported she did not observe signs of distress, urgency, or unusual behavior at the time the individual exited the building. She further stated she was unaware at that time that the individual was a resident of the facility. Review of Resident R1's clinical record revealed an Elopement Observation dated 5/10/26, which consisted of the following questions and documented answers: Is resident ambulatory or independent in wheelchair locomotion?YesDoes the resident have any of the following risk factors?New admission who has made statements questioning the need to be here - yesIs there been known history of attempted or actual elopement or unsafe wandering - yesNot accepting present residency situation/location - noResident wanders without a sense of purpose - noDoes the resident have a history of substance abuse History (SUD) that may result in leaving the building - noResident exhibits exit seeking behaviors - yesResident verbalizes, wanting to go home, going on a trip, going to meet someone - yesResident wanders in and out of other resident rooms and/or rummages in other's belongings - noCurrent acute change in cognition/confusion - noNone of the above criteria are currently exhibited - noPotential elopement risk identified, requires further review immediate intervention(s) implemented to address the identified risk factor(s) fillable sectionYesNo identified risk(s) for elopementNoImmediate intervention(s)Wander guard Score 8 - Level: currently has potential risk for elopement Review of facility-provided documents revealed a Root Cause Analysis that stated, Upon completion of the facility investigation, the interdisciplinary team determined the root cause of the event to be a breakdown in secured access control and monitoring during visitor/family movement through the Memory Care Unit, elevator access area. During visitor/family movement through the Memory Care Unit elevator area, the resident was able to follow through the elevator access point unnoticed, resulting in unauthorized exit from the Memory Care Unit. Review of facility-provided documents revealed a Plan of Correction dated 5/11/26. The document indicated employees were re-educated regarding elopement prevention, visitor management, and Code [NAME] procedures. Reinforcement was provided that door codes of the center and Memory Impaired Unit are confidential and intended for employee use only. Elopement prevention and visitor management practices were incorporated into ongoing employee education and orientation. During an interview on 5/19/26, at 11:42 a.m. LPN Employee E2 and LPN Employee E3 stated, Usually the RN Supervisor does the elopement assessments, we haven't done one in a while. Supervisors do the new admission assessments for all shifts. I'm not sure what the elopement assessment score is. I don't remember the score being address in the elopement education. During an interview on 5/19/26, at 11:48 a.m. Receptionist Employee E11 stated, We have an elopement binder at the front desk. It gets updated when there is a new admission identified as an elopement risk. The supervisor will let us know when it's updated. During an interview on 5/19/26, at 11:56 a.m. RN Employee E4 stated, I don't know what the score means on the elopement evaluations. The supervisor is usually who completes the assessments. During an interview on 5/19/26, at 12:00 p.m. LPN Employee E6 stated, I've never done one of the elopement assessments. Initial assessments for new admissions are done by the supervisor. Usually the supervisor does the quarterly assessments. I'm not sure what the elopement score means. During an interview on 5/19/26, at 12:01 p.m. RN Manger Employee E5 stated, During day shift, usually the unit manager or supervisor will complete the assessments. On the 3 p.m. - 11 p.m. shift there is only one supervisor and the majority of the admissions come on 3-11 so the other staff members will pick up tasks like vitals, height, weight, belongings, medication orders. Usually it's one person doing the assessment, but all nurses are able to complete the assessments. Everyone works together to get it done. Every resident is a bit different, the elopement assessment questions asks if residents are stating they don't want to be here, is there a history of wandering, are they ambulatory. You can pretty much tell who is going to be a risk and who isn't. I'm not sure what the magic score number is, I think it might be 5. During an interview on 5/19/26, at 12:48 p.m. the Nursing Home Administrator (NHA) and DON stated, There is no hard score for the elopement assessment, per the policy. It doesn't state that if you score X, you (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	are automatically an elopement risk. Anyone can do the assessments, it's not just the supervisor completing the assessments. During an interview on 5/20/26, at 9:03 a.m. the NHA stated all staff members received education on elopement prevention, visitor management, and Code [NAME] procedures. During an interview on 5/20/26, at 9:20 a.m. Regional Director of Clinical Services Employee E13 confirmed the facility policy Elopement Unauthorized Absence does not include guidance on how to identify a resident as an elopement risk or follow-up direction for staff after a resident has been identified as an elopement risk. On 5/20/26, at 9:36 a.m., the NHA was made aware that Immediate Jeopardy (IJ) was called due to the elopement of Resident R1 on 5/10/26. The NHA was provided an Immediate Jeopardy template, and a corrective action plan was requested. On 5/20/26, at 10:48 a.m. the facility provided a list of in-house staff members with documentation indicating the facility had 129 in-house staff members. 117/129 of in-house staff members had documentation that they received education on elopement prevention, visitor management, and Code [NAME] procedures on 5/11/26. On 5/20/26, at 11:17 a.m. the facility provided additional documentation indicating 127/129 in-house staff members received education on elopement prevention, visitor management, and Code [NAME] procedures on 5/11/26. On 5/20/26, at 11:18 a.m. Human Resources Employee E14 provided a list indicating the facility had six agency staff members and seven therapy services staff members. Facility-provided documentation indicated 6/6 agency staff members and 7/7 therapy services staff members had received education on elopement prevention, visitor management, and Code [NAME] procedures on 5/10/26, 5/11/26, and 5/12/26. On 5/20/26, at 4:47 p.m. an acceptable Corrective Action Plan was received which included the following interventions: The elopement policy was reviewed without revision by the Administrator and Director of Nursing Services on 5/10/26. All residents had new observations completed and interventions put in place by the Social Services Director and/or Administrative Nurse Representatives on 5/10/26. All care plans and orders were implemented/revised in accordance with new elopement observations by the Director of Social Services and/or Licensed Nurse Representatives on 5/10/26. Additional review of care plans were conducted, reviewing and revising as needed to support increased individuality in approaches and interventions. By the Director of Nursing and/or Licensed Nurse Representatives on 5/20/26. Staff including those working onsite and offsite on received required education, off site staff were individually notified and educated upon contact. Completed by the Administrator and Mangers on 5/10/26. Reception staff was educated on sign in/sign out expectations related to reception by the Business Office Manager on 5/20/26. Staff including those working onsite and offsite on received required education, off site staff were individually notified and educated upon contact. Completed by the Administrator and Managers on 5/10/26. The center implemented and educated on a licensed nurse elopement risk monitoring and intervention process for residents identified as at risk for wandering or elopement. The implemented process includes enhanced expectations for timely reporting and communication of wandering behaviors, completion of licensed nurse observations in response to identified behaviors or triggering events, and development and implementation of individualized interventions based upon resident-specific risk factors and behaviors. As part of the new process, licensed nurses were provided with standardized education, intervention examples, and an elopement prevention resource toolkit intended to support ongoing assessment, monitoring, documentation, and individualized care planning practices. Education and implementation of the new process were completed by the Director of Nursing and/or Administrative Nurse Representatives to be completed by 5/20/26. Additional reviews of care plans were conducted, reviewing and revising as needed to support increased individuality in approaches and interventions on 5/10/26. All care plans and orders were implemented/revised in accordance with new elopement observations by the Director of Social Services and/or Licensed Nurse Representatives, on 5/10/26. Root Cause Analysis: residents were not reassessed at risk for elopement after expression of wanting to leave the center, in addition to unattended elevator access and reception intervention as determined by the Administrator and Director of Nursing. Daily elopement prevention and access monitoring audits are (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	being conducted by the Director of Nursing/Designee to monitor compliance with elopement prevention practices, visitor and employee access procedures, staff assistance practices and education completion to ensure reasonable and practicable precautions are maintained to reduce a foreseeable risk. 5/11/26 and 5/19/26 QAPI (Quality Assurance and Performance Improvement) ad hoc (done as needed) review of audits have demonstrated success results during the review period. As completed by the Administrator and Director of Nursing implemented 5/10/26. On 5/21/26, at 9:15 a.m. it was verified 168/168 residents had new elopement observations completed on 5/10/26. 16/168 residents were identified as at risk for elopement. 16/16 resident physician orders were verified for an electronic monitoring bracelet. 16/16 care plans were reviewed and updated to include interventions to prevent elopement. On 5/21/26, at 9:24 a.m. it was verified 34/35 licensed nurse staff received additional education regarding elopement risk monitoring and intervention process for residents identified as at risk for wandering or elopement. 8/8 staff members identified as receptionists or fill-in receptionists received education related to visitor sign in/sign out expectations related to elopement prevention and center safety. Review of facility-provided documents on 5/21/26, at 9:30 a.m., revealed the facility had 129 employees, six agency employees, and seven therapy services employees. 140 employees signed they received formal education on elopement prevention, visitor management, and Code [NAME] procedures on 5/10/26, 5/11/26, and 5/12/26. During employee interviews on 5/21/26, from 10:09 a.m. through 1:30 p.m. 37 employees confirmed they had received education on the facility's elopement prevention, visitor management, Code [NAME] procedures, and elopement risk monitoring and intervention process for residents identified as at risk for wandering or elopement. During employee interviews on 5/21/26, the State Agency identified two staff members who stated they worked through a staffing agency and denied they had received education from the facility regarding elopement prevention, visitor management, and Code [NAME] procedures. Review of the facility-provided agency employee list failed to include the names of the two identified staff members. During an interview on 5/21/26, at 11:15 a.m. the State Agency requested an accurate list from the facility containing all staff members who work through a staffing agency. During an interview on 5/21/26, at 12:45 p.m. Human Resources Employee E14 stated an updated agency list was being printed at that time. During an interview on 5/21/26, at 1:47 p.m. the State Agency still had not been provided an accurate list containing all agency staff members, which had previously been requested on 5/21/26, at 11:15 a.m. During this interview, the NHA stated, I was not aware that all agency staff members needed to be educated. During this interview, the NHA confirmed that the facility did not provide education to all agency staff members on elopement prevention, visitor management, and Code [NAME] procedures as previously stated by the facility. On 5/21/26, at 2:08 p.m. it was verified the facility had 14 residents currently identified as elopement risks. 14/14 resident physician orders were verified for an electronic monitoring bracelet. 14/14 care plans were reviewed and updated to include resident-centered interventions to prevent elopement. On 5/21/26, at 3:20 p.m. a list was provided to the State Agency containing 40 employees who work through a staffing agency. 22/40 agency employees had signed that they received education on elopement prevention, visitor management, Code [NAME] procedures, and elopement risk monitoring and intervention process for residents identified as at risk for wandering or elopement. Human Resources Employee E14 stated phone messages were left for the remaining 18 agency employees and those employees would receive education prior to working their next scheduled shift at the facility. The Immediate Jeopardy was lifted on 5/21/26, at 3:27 p.m. when the action plan implementation was verified. During an interview on 5/21/26, at 3:27 p.m. the NHA confirmed that the facility failed to ensure proper supervision for a resident (Resident R1) resulting in an elopement from the facility, resulting in Immediate Jeopardy. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing Services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility by failing to ensure proper supervision for a resident (Resident R1) resulting in an elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) from the facility on 5/10/26, which created an immediate jeopardy situation for all residents identified as an elopement risk.Findings include: The job description for the Nursing Home Administrator specified the primary purpose of the job position is to lead, direct, and manage the overall operations of the community in accordance with policies and procedures and current federal, state and local standards, guidelines and regulations that govern the community. As the Administrator, it is your responsibility to organize, develop and direct resources to maintain the highest degree of quality care is maintained for each resident at all times. The Administrator will also plan, implement and achieve the community's business objectives. The job description for the Director of Nursing specified the purpose of the job is to organize, develop, manage, and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the community. The DON is to work directly with the Administrator and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. Based on findings identified in this report, the facility failed to ensure proper supervision for a resident, resulting in Resident R1 eloping from the facility, which placed the resident in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 5/20/26, at 9:36 a.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for all residents identified as an elopement risk. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395682	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on review of facility files and staff interview, it was determined that the facility failed to employ a full-time qualified social worker from February 16, 2026, through present.Findings include: Review of Social Worker Employee E12's personnel file indicated a Bachelor of Science degree and a Certified Therapeutic Recreation Specialist certificate. Review of the resume for Social Worker Employee E12 indicated education that included bachelor's degree coursework in Recreational Therapy. During an interview on 5/21/26, at 1:30 p.m. with the Nursing Home Administrator indicated that the Bachelor of Science degree and Certified Therapeutic Recreation Specialist certificate qualified the employee for the position of social worker. During an interview on 5/21/26, at 1:33 p.m. the Nursing Home Administrator refused to confirmed that the Social Worker Employee E12 failed to have a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.16 (a) Social services